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Taking the Next Step: Options and Support for a Pan-Canadian, Multi-Professional HHR Planning Mechanism

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As always, the views expressed in this document are those of the authors and may not reflect the opinions of any of the organizations or individuals noted above or of Canadian Policy Research Networks itself. Any errors or misrepresentations are the sole responsibility of the authors.

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Executive Summary

It is generally accepted within the health care sector that human resource planning is a critical component in successfully implementing any health reform initiative. Individual jurisdictions, regions and health professions have developed a number of health human resource (HHR) models, tools and innovations; however, the information experience does not always cross jurisdictions or professions. As a result, there has been renewed interest in examining mechanisms that could support a more coordinated approach to HHR planning.

This study is designed to accomplish two goals. The first is to propose potential options for creating a pan-Canadian HHR planning mechanism or mechanisms to better serve the process of coordinated HHR planning across jurisdictions and among multiple professions. The second goal is to assess the current level of support among both government actors at the federal, provincial and territorial levels and stakeholder organizations for creating a pan-Canadian HHR planning mechanism or mechanisms, specifically examining the potential mandate, structure, governance, accountability and resource needs of these options. To accomplish these goals, the study examines the current HHR planning infrastructure in the country, recent international developments in HHR planning, the attitudes of key informants in governmental and non-governmental communities as revealed in a series of one-on-one interviews and the results of an online survey. This analysis, thus, roots the resulting options in an understanding of the current HHR planning environment in the country, its accomplishments and its ongoing challenges.

The issue of whether there is both a need for and a willingness to create such a mechanism or mechanisms is not a new one. Its currency among governments and stakeholders has waxed and waned for at least the past decade. As evident in the discussion below, there is much agreement that more coordination in HHR planning both across jurisdictions and professions is needed, but also much disagreement over how best to accomplish that coordination. In short, the general agreement about the need for better coordination begins to break down over issues such as:

- The form that coordination should take;
- The structures that need to be in place to accomplish better coordination and the mandate of any pan-Canadian, inter-professional mechanism;
- The relative role of both governments and stakeholders in any proposed planning mechanism(s) in terms of governance, accountability and financing; and
- The mandate that any mechanism(s) might be given.

The more specific one gets when discussing these kinds of issues, the more individuals begin to fall into different camps and to express disagreements about specific issues.

That being said, it is also clear from key informant interviews conducted as part of this study that there is a very strong sense that without significant progress on the issue of coordinating HHR planning in the country that the accomplishments of individual jurisdictions and professions in assembling better data, building better models and forecasting HHR needs in light of population health needs (and a host of other activities) may well come to naught. These accomplishments run the risk of being undermined and perhaps even nullified by the inability to effectively take into account changes that are occurring elsewhere in the system both at the level of HHR planning and in terms of non-HHR changes in the organization and delivery of services. What is evident is that there is a real desire on the part of all actors to push HHR planning away from supply-demand models based on past utilization towards models firmly rooted in the health needs of populations served – a move that forces us to begin to integrate changing societal trends and issues from outside the health service delivery arena into our thinking about future HHR needs.

It is also clear that there is a real divide between those interviewed from stakeholder organizations (the health professions and non-governmental health care interest groups) and government officials. On the one hand, stakeholders tend to feel that it was governments' inaction that accounted for the failure to make progress on the idea of a pan-Canadian HHR planning mechanism after the release of both the Kirby and Romanow reports, when the issue was last placed squarely on the policy agenda. This has been tempered by stakeholder organizations recognizing the importance of working with governments, not simply lecturing.

Government officials, on the other hand, expressed frustration with stakeholder and interest groups' inability to understand both the policy and political sensitivities of potentially investing in yet another organization or structure with oversight or monitoring responsibilities that were unclear and unaccountable to governments, which had to balance their HHR planning responsibilities with a host of other priorities and demands on their time and resources.

To some extent, the crux of the issue is essentially political. The shared desire is for a mechanism(s) that can assist governments and stakeholders in making HHR planning decisions so that the actions of one individual government are not undercut by the actions of another government. For example, decisions over how many health practitioners will be needed in the future to meet the health needs of the Canadian population must take into account not only those changing health needs, but also the changing number and role of the other health professions in the system that is itself evolving into different models of health services delivery and increasing privatization of services provided by many regulated health care providers. Indeed, beyond the physicians and nurses working in hospitals or private practices, an increasing number of health professionals and professions (psychology, physiotherapy, dentistry, optometry, etc.) are delivering services that are, at best, only partially covered by provincial health insurance plans. Many of those services are wholly privatized and accessible only to those who can afford them. How and whether those services are accessed by Canadians poses real HHR planning challenges if we take seriously that (a) these are services are every bit as

"medically necessary" as those provided under the *Canada Health Act*; and (b) we need to increasingly think in terms of the health service needs of populations in a more holistic manner.

At the same time, what that mechanism does, how it is structured, governed, financed and how it goes about its work has to take into account the very real jurisdictional issues that exist in Canada's highly decentralized federation – at least insofar as it focuses on the publicly insured services provided by provincial insurance plans. The fact that government decisions have to balance priorities of which HHR planning (and even health care more generally) is but one. There are very real disagreements between and among both governments and stakeholders about what the future of health service delivery can and should look like in this country, which need to be taken into account.

It is also clear from the discussions with the key informants that while the interest in a pan-Canadian mechanism is still strong, the political and policy landscape has changed somewhat in the years since the recommendations contained in the Kirby and Romanow reports were developed. As such, any discussion of what a mechanism or mechanisms might look like has to take into account both the changed political and policy landscape that now exists, as well as the progress that has been made in HHR planning in jurisdictions across the land. There is a recognition that any proposal must be shaped by the studies, information and structures in place. The mechanism would facilitate HHR planning and program implementation, not duplicate or replace current structures. With this in mind, the report concludes with a discussion of some potential options and possibilities for a future mechanism(s) that might prove to be worthy of further development and analysis by governments and stakeholders.

Before laying out the options, however, this report makes some observations about the potential mandate of the HHR planning mechanism. On the premise that form must follow function, we have attempted to distil – from the literature, our international scan, the key informant interviews and the electronic survey – some sense of what the initial mandate for such a mechanism might be. In our view, the mechanism's mandate could include any or all of the following:

- Synthesising and analysing existing data and data sets;
- Synthesising existing research in HHR planning on behalf of all actors within the system;
- Serving as a clearing house on best practices for both governments and stakeholders;
- Serving as a developer of needs-based interprofessional HHR planning models on behalf of governments and other actors;
- Serving as a neutral forum for system actors to engage in open discussion and assessment of HHR planning policy options; and
- Transferring and exchanging knowledge related to HHR issues and health system design needs.

Some of the key informants went further in terms of suggesting a mechanism that would provide advice to governments around best practices and system restructuring. But it was equally clear that the closer the mechanism got to what could be called an "advocacy" role or to making recommendations on what a government "should" do (as opposed to "could" do), the greater the key informants from inside government resisted this notion. That governments might be more amenable to having the mechanism play such a role in the future (after having demonstrated its usefulness in terms of the above activities) is something that is decidedly unclear, but worth considering further down the road.

In terms of the options themselves, there are clearly some design options that now appear to be off the table. For example, there is no appetite for creating a fully-fledged stand-alone operation with significant in-house research or support staff in the mould of the Health Council of Canada. Rather, there is an emerging consensus that the HHR mechanism needs to be a smaller organization relying as much on building networks of researchers, analysts, stakeholders and decision-makers as on in-house analytic or research capacity.

Briefly, then, we describe three options:

1. A small secretariat reporting to governments that serves as the hub of a series of research and analytic networks located in other institutions and organizations.
2. A small secretariat located within an existing research organization (e.g. the Canadian Institute for Health Information), but with a modified reporting and accountability structure to include government and stakeholders.
3. A small research secretariat jointly accountable to both governments and stakeholders that, again, serves as the hub of a larger network of researchers and organizations.

Each of these options has both strengths and weaknesses. None is without some potential risk as well as some potential reward. But what is clear is that there is a willingness on the part of governments and stakeholders to revisit the issue of creating one or more pan-Canadian HHR planning mechanisms. While there is no strong consensus on any single model or mandate for a mechanism, there is recognition that, given the progress that has been made in recent years on a number of fronts, the next step is considering some vehicle that could consolidate and build on that progress. Thus, a window of opportunity exists for a more sustained discussion of the kinds of options that are presented above. They are not the only options that might be considered, but they do constitute a starting point for figuring out how to take the next step and in what direction we might choose to head.

Taking the Next Step: Options and Support for a Pan-Canadian, Multi-Professional HHR Planning Mechanism

1. Introduction

The issue of whether there is a need to create a pan-Canadian, multi-professional health human resource (HHR) planning mechanism (or some combination of mechanisms) that would, in some concrete ways, provide services and advice to both governments and stakeholder organizations, is not a new one. Yet, despite having been on the radar of some governments and most national stakeholder organizations for close to a decade, there has been little discernable progress in finding a vehicle that could consolidate the progress that has been made on HHR planning in recent years or better coordinate and share ongoing and future activity in this area.

Precisely because HHR planning is the key hot-button issue in health care policy as it relates to the publicly administered, publicly financed delivery of health care services, the issue of how best to coordinate activity, share information, transfer best practices and disseminate policy-relevant knowledge is fraught with sensitivities and political concerns for both governments and non-governmental organizations (NGOs). At the same time, the policy environment for HHR planning is always somewhat fluid. Issues or ideas that were at one time unworkable or unachievable can again find a place on the policy agenda of governments.

In his now classic deconstruction of policy-making, Kingdon wrote that policy choices move from being on a government's radar, to being on the government's agenda, to developing options to taking decisions and implementation as a result of the intersection of ideas, interests and institutions that coalesce to take advantage of a window of opportunity for action.[1] Those windows open and they close – there are times when action can lead to fundamental change and other times when that same action will leave you with your nose pressed up against the glass.

Up to this point, those who have favoured creating some kind of pan-Canadian HHR planning mechanism that would work across both jurisdictions and professions have been on the outside of a closed window. Past attempts to create such a mechanism – most notably in the aftermath of the Romanow Commission (2002) and the Kirby Report (2002) – have yielded little of substance. But there is some evidence that the environment has changed (or is changing) and that if the window is not exactly wide open at this point, then it at least is partially open. This opening of an opportunity rests on a number of factors.

First, the very fact that HHR planning is, for all intents and purposes, the most important issue facing the health care system in Canada and is seen as the key to making progress on a host of other health care and service delivery reform initiatives, that have long been on the agenda, has focused government attention on HHR issues of supply, demand, skill mix, professional mix, population needs-based planning, etc. to what seems an unprecedented degree.

Secondly, the NGO community of health system stakeholders have themselves undertaken wide-ranging and important steps in coming to grips with their own HHR planning issues and have begun to link their own profession-specific issues with those of other professions. The completed sector studies in nursing and medicine as well as the ongoing studies in other professions such as pharmacy have highlighted both the challenges and opportunities that would come from more coordination of planning across professions and jurisdictions. And, it has to be admitted, the NGO community has been much clearer and more forceful in presenting a common position on these issues than it has in the past such that it speaks to governments in a single voice.

Thirdly, governments have begun to collaborate more effectively on HHR issues. Although they remain a long way from fully-fledged collaborative planning, the development of the Pan-Canadian Framework for HHR Planning agreed to by all jurisdictions, the existence of forums such as the Western & Northern HHR Planning Forum and other joint activities, all point to a greater willingness to engage with each other, share information and understand how the actions of one can affect the others.

Fourthly, research in HHR planning has begun to move beyond single profession supply and demand models towards developing more sophisticated models that are taking into account existing and emerging population health needs and an understanding that one cannot plan for a single profession in isolation from other providers.

Thus, these factors all point to, as the title of this report suggests, "the next step" – creating some sort of mechanism that could coordinate, consolidate and move forward to assist governments in making the policy choices necessary to plan more effectively in the future than they have in the past.

But as always, the devil is in the details. As is noted below, there is a reasonably strong consensus on the issue that something is needed in terms of a mechanism to get governments and stakeholders to that next step, but there remains some differences on what exactly that "something" should look like, what its mandate would be and how it would be structured and operate.

It is also the case that if the mechanism, whatever its shape and mandate, is to be truly pan-Canadian and multi-professional, then it will have to deal with HHR planning issues as they relate to the interface of both the public and private realms and the health professions that operate within both. If a key goal of HHR planning is to lay the groundwork for Canadians' ability to access a seamless continuum of care, then we have to acknowledge that that continuum crosses back and forth across a number of public/private dimensions:

- Publicly financed, but privately delivered care;
- Publicly financed and publicly delivered care;
- Publicly subsidized, but privately delivered care; and
- Privately financed and delivered care.

And to complicate this matter further, it can make a difference whether the care is delivered by a private not-for-profit organization or on a for-profit basis.[2] Roughly 30% of Canadians' health care spending is from private insurance or direct-out-of-pocket payment. Significant numbers of health providers (e.g. physiotherapists, psychologists, optometrists, dentists, etc.) operate either partially or wholly outside the publicly administered, publicly financed health delivery systems in Canada. As services are de-listed from provincial health insurance plans, as community-based care grows in significance and as we turn our attention to some of the "orphans" within the health care system (e.g. mental health care), then we must think seriously about how the HHR issues for those providers get pulled into our thinking about HHR planning such that it focuses on the real continuum of care experienced by the patient. We must also be cognizant that, in time, we will need to confront the fact that some part of that continuum of care exists in what would generally be considered non-health care services provided by both private and public social services agencies and organizations.

Yet much of the focus of governments, the media and indeed even the NGO community remains fixed on the HHR planning issues within the publicly financed sectors of the health care system. For too many, HHR planning is about the number of physicians and nurses present in their jurisdiction and not about the full spectrum of health care services (let alone non-health care social service supports) to which Canadians expect access. There is an increasing focus on pharmacist services in many jurisdictions, but a whole range of professions that are integral to the health status of populations are often sidelined in HHR planning discussions. One of the key challenges for any planning mechanism will be to find effective ways to draw in those professions too often sidelined in the current discussions.

To return to Kingdon's model, the issue of a pan-Canadian, multi-professional HHR planning mechanism is clearly on the radar of both governments and stakeholders (i.e. the issue has been identified as an issue). We can go further and say the issue is on the agenda of at least some governments. Virtually all of the stakeholders (i.e. actors) have concluded that action is needed on the issue. Further still, a few governments and some of the stakeholders have some clear options under development or in mind (i.e. they have begun to flesh out what options are possible). But we are not yet at the point of making a decision over which option should be pursued.

Thus, the window of opportunity clearly exists for a much more extensive discussion between governments and stakeholders (and also among governments themselves) in terms of getting the issue on the agenda of more governments and refining the possible options. The options sketched out in the final section of this paper, then, are meant as the basis for exactly that kind of conversation. That conversation can be designed to refine the idea and bring more of the interests and institutions that will have to be accommodated into line around a common understanding and common goal.

2. The Report's Structure, Methods and Limitations

This report is broken down into a series of sections that essentially reflect the different stages of the analysis as it progressed. First, there is a review of the existing literature in Canada on the issue of a pan-Canadian HHR mechanism from 2000 to 2007. Only documents that addressed a pan-Canadian approach were examined.

Secondly, there is an examination of the existing HHR planning infrastructure in Canada. Our primary focus here was to look at mechanisms currently in place that provided some institutional and policy support for HHR planning on an ongoing basis.

There follows from this a brief discussion of some other sectors in Canada where there exists a more coordinated but focused approach to HHR planning. Included in this section is a discussion of the role played by sector councils and the sector studies undertaken within the health sector.

As part of the investigation, we looked specifically at the international community for guidance around how one might structure and charge a pan-Canadian HHR planning mechanism. The key caveat here is that all of these models are relatively new, so there is still a great deal to be learned about how effectively they solve the HHR problems in those countries.

Perhaps the most important part of the analysis was the nearly 30 key informant interviews with government officials, representatives of key stakeholder organizations and others across the country (see Appendix I). These were designed to elicit information regarding the level of support for both the concept of a pan-Canadian HHR planning mechanism as well as to probe more deeply into the specifics of mandate, structure, governance and financing of any of their preferred models.

The last element in the analysis was developing an electronic survey that was sent on our behalf to a wide array of representatives from stakeholder organizations across the country. A total of 332 responses were recorded. The very strong caveat that has to be placed on the data collected from the survey, however, is the recognition that it was a self-selected group that chose to answer the survey and, as such, they may well tend to have much more strongly held views on the issue than a random cross-section might. It is also strongly weighted towards members of professional associations or health providers with governments, unions and other actors within the health system significantly under-represented.

The final section presents options that flow from analysing the various components of this project. In this regard, we were helped considerably by a piece of work originally commissioned by Health Canada from the Brown Governance consultants that outlined some options for a similar mechanism.[3] This work, undertaken shortly after the recommendations of the Kirby and Romanow reports, put the issue of a pan-Canadian mechanism on the intergovernmental agenda and provided a key baseline from which to develop options in light of changing attitudes and circumstances.

3. The Canadian Literature

The idea that Canadian governments, stakeholders and policy-makers need some kind of pan-Canadian mechanism to assist them in terms of data analysis, modelling and other activities first began to emerge around 2000. One of the first crystallizations of this thinking in the research literature comes from the work of Canadian Policy Research Networks (CPRN) on behalf of the Romanow Commission that reported in 2002. At the same time, a "grey literature" emerges from governments and stakeholders that articulates HHR planning needs and potential mechanisms, sometimes in a pan-Canadian sense, sometimes in a provincial or interprovincial sense and sometimes in a profession-specific sense. Generally speaking, when one goes through the grey literature, there is an enthusiasm for a HHR mechanism by various stakeholders and governments. What is less apparent is what it would look like and who would take responsibility for its implementation and ongoing operations, and how and by whom it would be funded.

There are several possibilities raised in the Canadian grey literature around the overall structure and scope of an HHR planning mechanism by both government and stakeholder groups. Health Canada, for example, in the report *Steady State: Finding a Sustainable Balance Point,* proposed a permanent National Workforce Planning Organization (NWPO) to coordinate HHR planning across Canada.[4] The NWPO would have a central advisory committee with linkages to other permanent governmental workforce planning staff and organizations, and research and health services organizations.

The possibility of a pan-Canadian HHR mechanism is also raised in two national commission reports. The Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, recommended, in its final report *The Health of Canadians – The Federal Role*, establishing a permanent national coordinating body for HHR planning, to be comprised of representatives from key stakeholder groups and from the different levels of government. Its proposed activities include, among other things, disseminating up-to-date HHR information, data and best practices, coordinating initiatives aimed at meeting workforce self-sufficiency, and coordinating licensing and immigration between the levels of governments.[5]

Likewise, the Romanow Commission, in its final report *Building on Values: The Future of Health Care in Canada*, recommends establishing a pan-Canadian approach to HHR planning. The Romanow Report recommendations were adapted from work undertaken by Canadian Policy Research Networks (CPRN) (published as *Health Human Resource Planning in Canada: Physician and Nursing Work Force Issues*),[6] which recommended establishing a Canadian Coordinating Office for Health Human Resources (CCOHHR) to collect, evaluate, synthesize and disseminate information. The authors outline several possibilities regarding its structure, which include a separate organization with its own governance structure and lines of accountability, using the Canadian Institute for Health Information (CIHI) as a model. Alternatively, it could be an extension of the federal-provincial-territorial (FPT) Conference of Deputy Ministers or the Advisory Committee on Health Human Resources.[7] Another option is establishing several standing HHR

planning research/policy institutes linked nationally through "a permanent virtual institute" as suggested by Tomblin Murphy and O'Brien-Pallas (2002).[8]

In the end, the Romanow Commission, in its final report, *Building on Values*, recommend integrating an HHR planning structure within the overall mandate of the Health Council of Canada. The proposed activities around HHR include collecting and analyzing information about the Canadian health workforce and developing a comprehensive plan for addressing issues related to the supply, distribution, education and training, remuneration, skills and patterns of practice for Canada's health workers.[9]

Several key stakeholder groups have also weighed in on the possibility of a permanent pan-Canadian HHR mechanism. One suggestion posed by the Canadian Medical Association and the Canadian Nurses Association in their *Green Paper on a Pan-Canadian Planning Framework for Health Human Resources*, is establishing a Canadian Coordinating Office for Health Human Resources (CCOHHR) modelled on the Canadian Coordinating Office for Health Technology Assessment (CCOHTA), now known as the Canadian Agency for Drugs and Technologies in Health.

The notion of a CCOHHR was expanded in *A Physician Human Resource Strategy for Canada*, the 2006 final report of Task Force Two. They recommend developing a "permanent body or mechanism (possibly virtual) with the capacity and mandate to foster a pan-Canadian and integrated approach to health human resources planning."[10] One of the main issues is whether or not the proposed body should be a stand-alone organization or housed within an existing organization such as the ACHDHR, the Health Council of Canada, the Canadian Medical Forum or the Conference of Deputy Ministers. It may also be a virtual structure, which connects various organizational structures. The CMA has taken these recommendations one step further by establishing a Canadian Coordinating Centre for Physician Resource (C3PR) in April 2006, which is discussed below.

The final report of the nursing sector study *Building the Future* also supports a Pan-Canadian approach to HHR planning. One of the recommendations is establishing an infrastructure for HHR planning "with the analytical capacity, infrastructure support, and a governance model to coordinate a pan-Canadian needs-based approach to health human resource planning."[11] Likewise, the Health Action Lobby (HEAL), a coalition of national health and consumer associations and organizations dedicated to protecting and strengthening Canada's health care systems**,** recommends establishing a Canadian Coordinating Office for Health Human Resources (CCOHHR).[12] Finally, the Canadian Health Association (CHA), within its *Policy Brief on Employability Issues Presented to the House of Commons Standing Committee on Human Resources, Social Development and the Status of Persons with Disabilities*, recommends a number of actions that support an HHR planning mechanism and better coordination of HHR planning, including establishing a clearinghouse(s) on important health system information.[13]

There is a general consensus that a pan-Canadian HHR planning mechanism(s) would be beneficial, leading to better integrated planning, improved forecasting and tools and better dissemination of information and best practices. What is emphasized in some of the literature is that the HHR planning mechanism draw on the work already undertaken by other organizations rather than duplicating efforts. For example, rather than conducting primary data collection, linkages could be made with CIHI to develop customized reports and/or assist with standardizing data definitions.[14] Another important element is the formation of integrated and interprofessional partnerships between stakeholders including governments, regulatory bodies, professional associations, academia, students, the private sector, First Nations, patients/the public and the mass media.[15] These partnerships could be linked through the forums recommended below. For example, as is noted by Fooks et al. (2002), an HHR planning mechanism or agency could provide a "neutral space" that would bring together various stakeholders to begin cross-sectoral discussions about policy initiatives.[16]

Another theme that emerges from the literature is that the HHR mechanism reflect provincial HHR landscapes, health service models and population health needs, and incorporate an analysis of evolving service delivery models, demographic changes, the private-public interface and technological changes.[17] According to Task Force Two, one of the primary functions of the HHR agency would be to track the "dynamic interaction between these various levels of needs and adapting it to HHR planning."[18] There are several activities suggested within the Canadian literature that could be integrated as part of the mandate or vision of a pan-Canadian HHR mechanism. They could range from providing a clearinghouse of information and best practices, to developing guideline and standards for information collection as well as identifying trends and gaps in information.

Most of the suggestions and recommendations stemming from the Canadian grey literature are made at a very high level. While there is general support for a pan-Canadian HHR mechanism, and suggestions made around its eventual structure and activities, the discussion often halts at the level of the "nuts and bolts" in getting a pan-Canadian HHR planning mechanism up and running. Partly this has to do with where it is located and what final shape it takes. The governance and financing of a stand-alone corporation is somewhat different than subsuming HHR as part of the mandate of an already existing organization or agency such as the Health Council of Canada.

4. Existing Canadian HHR Planning Infrastructure

There has been considerable activity around HHR planning in Canada in the past few decades. A host of conferences, commissions, forums and meetings have been held in recent years around identifying the problems and exchanging solutions, mostly reaffirming the need for greater coordination. Yet there are certain operational issues here. First of all, there are a number of one-off events or activities that are not necessarily translated into an infrastructure. Secondly, even if there is a translation into infrastructure support, there is seldom any permanency. Thus, there is more of an "ebb and flow" to the Canadian HHR planning infrastructure as new, often one-off committees, working groups or forums are suggested, put into place and then dismantled once a report has been released or funds have run out or are cut. Thirdly, HHR planning in Canada tends to be done in isolation rather than reflecting any real coordination.

This is not surprising given the diversity of actors in the Canadian health systems, which have different political agendas, not to mention specific roles and responsibilities for service delivery. This was addressed by the Advisory Committee on Health Delivery and Human Resources (ACHDHR) in December 2005 when it released the first iteration of a Pan-Canadian Framework for HHR. This framework sets out the goals, objectives and tangible outcomes related to specific HHR concerns and issues, including the expected standards around recruitment and retention strategies, and improving planning by taking a population health approach. The issue here is one of coordinating actions in order to meet the expected goals.

The following summarizes the current HHR landscape in Canada.

At the intergovernmental level, the ACHDHR was established in 2002 by the Conference of Deputy Ministers (CDM) of Health to provide policy and strategic advice to the Conference of Deputy Ministers on HHR planning issues, and be a forum for FPT information sharing and discussion.[19] Another intergovernmental activity is the Joint Task Force on Public Health Human Resources (JTF PHHR), which provides long-term planning, forecasting, research, education and training related to public health HHR. Finally, the Health Council of Canada was implemented as an intergovernmental organization to monitor the commitments made by federal, provincial and territorial governments in the 2003 and 2004 Health Accords agreed to by Canada's First Ministers, one area of which is HHR.[20]

At the federal level, a Health Human Resource Strategy was established to improve HHR planning and coordination between the provinces, territories and other health-related organizations. The Strategy funds initiatives in the following three critical areas: Health Human Resource Planning; Recruitment and Retention; and Interprofessional Education for Collaborative Patient-Centred Practice. Under the theme of Recruitment and Retention is an Internationally Educated Health Professionals Initiative, which is aimed at improving the integration of internationally educated physicians, nurses, medical laboratory scientists, medical radiation technologists, pharmacists, physiotherapists and occupational therapists.[21]

The federal government has also implemented an Aboriginal Health Human Resources Initiative,[22] the focus of which is: increasing the number of Aboriginal people working in health careers; integrating cultural competencies within educational curricula; and improving the retention of health workers in Aboriginal communities.

Provinces have also formed ad hoc regional collaborations to address issues of mutual concern and interest. These include the Western & Northern Health Human Resources Planning Forum,[23] and the Atlantic Health Human Resource Association.[24] The main objective of the Western & Northern Health Human Resources Planning Forum, for example, is "to provide a forum where western provincial and northern territorial ministries of health and advanced education can explore opportunities for co-coordinated planning and joint initiatives in the area of health human resources."[25] Their activities became more formalized and structured with financial assistance from Health Canada in support of specific research, planning and the coordination of activities.

There are few non-governmental activities in Canada that focus on HHR planning per se. There are, however, some foundations and not-for-profit institutes, including the Canadian Health Services Research Foundation (CHSRF),[26] Canadian Policy Research Networks[27] and the Canadian Institute of Health Research,[28] which prioritize the management of and funding for, issues pertaining to the Canadian health care workplace as one aspect of their overall mandate.

Collaborations and coalitions between professional groups also play an important role in HHR planning across Canada. For example, the Quality Worklife – Quality Healthcare Collaborative[29] was initiated to provide both research and advocacy for improving quality health workplaces. Other initiatives that focus on Canadian interprofessional or professional-specific HHR planning include the Health Human Resources Planning Simulation Model for NPs in Primary Health Care™,[30] the Health Action Lobby (HEAL),[31] the Canadian Association of Occupational Therapists Human Resources Working Group[32] and the Canadian Coordinating Centre for Physician Resources (C3PR). The C3PR is the successor or the inheritor of the work of Task Force Two on Physician Resources. Its goal is to undertake and participate in research that examines the supply, mix and distribution of physicians in Canada.

The Canadian HHR landscape also includes structures that collect and disseminate data on the supply of HHR in Canada. These include the CIHI Health Human Resource Databases,[33] the National Physician Survey (NPS),[34] the Canadian Post-MD Education Registry (CAPER)[35] and the Canadian Nurses Association/Canadian Association of Schools of Nursing Student and Faculty Survey Reports.[36]

4.1. Observations

The above outline of the key elements of the existing HHR planning infrastructure admittedly captures only certain dimensions of what is happening on the ground. The very fact that it mostly excludes the activities of individual provinces (or of sub-provincial units such as regional health authorities) means that significant pieces are missing from the discussion. But, insofar as we are interested in the idea of a pan-Canadian, multi-professional HHR planning mechanism, there was a rationale for those exclusions.

Even with that very important caveat, there are some interesting things that stand out. First, much of the research being done outside governments or stakeholder communities is being done, it seems, by individuals or teams of academic researchers who are both isolated from one another and isolated from the policy-makers and stakeholders for whom their research is presumably of the most interest. But there is evidence that this is changing insofar as funders, such as CHSRF and CIHR, are insisting that larger research teams have advisory committees that include policy-makers, although this not the case for individual research grants held by single researchers or small groups of researchers.

Secondly, the initiatives around data collection and data analysis led by organizations such as CIHI are improving every year – something noted by a number of the key informants interviewed. There remain a number of unenumerated databases held by individual organizations and groups (professional associations, regulatory bodies, employer associations, etc.) that could and should be a source for both research and policy analysis. There is also a great deal of important data held by private sector actors that are not easily accessible by other actors in the system.

Thirdly, there appears to be a couple of parallel tracks developing in terms of the work being done by governments on the one hand (individually, interprovincially and intergovernmentally) and that being done by stakeholder/NGO organizations, either singly or in concert with one another. While there appears, on the face of it, still a tendency for some stakeholder organizations to work independently rather than collaboratively on some initiatives, there is also evidence that this is changing and that more and more initiatives are being undertaken collaboratively and on a multi-professional basis. The CMA's C3PR initiative is an important attempt to keep the work of Task Force Two alive and moving forward, but it is not clear yet how well it will or can integrate the findings of the other sector studies (both completed and ongoing) into its analysis. It is a truism of HHR planning that in the current context of wanting to move forward on key health reform initiatives, such as primary care reform, rethinking scopes of practice and needs-based funding models, one cannot plan for one profession in isolation from the other health care providers in the system.

While governments have certainly made important progress in developing the Pan-Canadian Framework for HHR Planning and their commitment to ensure that the document remains "ever-green" over the next number of years, there is still some significant uncertainty over whether the Framework will herald much change on the

ground – again something raised by some of the key informants interviewed for this study. So, it appears the work of governments and the work being undertaken or sponsored by the stakeholder/NGO communities are operating in some degree of isolation from each other.

Finally, it is obvious that there are few if any structured processes for disseminating, coordinating and cross-pollinating these activities. As such, it is difficult in some sense to even talk about a pan-Canadian HHR planning infrastructure, which implies not only some degree of permanence, but also some degree of linkage, coordination and mutual support. It is apparent that there is a great deal of work being done, but one has to wonder how much of the knowledge being generated is getting into the hands of those who need it (or who should have it whether they know they need it or not) in an appropriate and timely manner.

But it would be misguided to assert that this is simply a case of bad knowledge translation or mobilization. It goes deeper than that. There remains an important element of research synthesis that is missing from the existing infrastructure – a process that draws the threads together into a more complete fabric. The work of governments focuses (somewhat understandably) on those parts of health care they are financially responsible for, thus the strong emphasis on hospital, institutional and physician care. The professional associations have made some progress in working together more collaboratively, but there still remains a public sector/private sector divide to much of the activity. It is in the doing of that synthesis that new research questions emerge, new understandings begin to develop and an ability to see both the forest and the trees begins to emerge.

It is also important to note that there are a number of actors, organizations and initiatives that, while they are important voices in the HHR planning discussion, are not, predominantly or exclusively, dealing with HHR planning issues. For example, any discussion of HHR planning must include input from intergovernmental organizations such as the Council of Ministers of Education (CME). Changes to how we train health professionals (and how many we train) cannot be made without the input of those responsible for planning and organizing primary, secondary and post-secondary education. But the CME's raison d'être is not HHR planning and, although its voice is one that must be included, the organization itself is not included in our outline of the existing infrastructure. The same is true for the intergovernmental equivalents of a number of government ministries (immigration, labour market, economic development, finance, etc.), all of which have a vested interest in certain aspects of HHR planning (e.g. the role of internationally educated health professionals), but for whom HHR issues are but one of many elements of their mandate. One of the key functions of any HHR planning mechanism, then, might indeed be to act as the point of contact for bodies, such as CME, to have input into the HHR planning activities.

Similarly there have been a host of research and planning initiatives in recent years, that while not permanent features of the HHR planning infrastructure, have still contributed to building the knowledge base and have influenced the direction of those more permanent organizations and bodies. For example, the projects initiated under the Health Transition

Fund administered by Health Canada and the Enhancing Inter-disciplinary Collaboration for Patient-Centered Practice projects have contributed significantly to the knowledge base of what works in terms of changing health care delivery models. Unfortunately many of these kinds of initiatives are essentially one-time events and pilots launched, even when successful, are often not made permanent features of the landscape. Again, it is important to consider the role that a more permanent HHR planning mechanism might play in both capturing the lessons learned from such initiatives and integrating those lessons into future work.

5. Looking to Other Models in Canada and Abroad

5.1 Sector Council Model

The sector council concept was developed as a way to understand the needs of specific industries, whose members may share common challenges. Initially, sector councils were formed to address the needs of industrial sectors of the economy such as steel, automotive parts, apparel manufacturing and tourism. Over time, it has been expanded to occupations such as police, child care or broader cross-sectoral approaches that address diverse interests such as apprenticeship training or skills development for Aboriginal people. There are now over 30 sector councils representing diverse areas of the Canadian economy

These permanent bodies bring together representatives from business, labour, education and other professional groups in a neutral forum in order to comprehensively and cooperatively analyze and address sector-wide human resource issues. Their overall goal is to improve the quality of the Canadian labour force, and to assist firms and organizations to be more flexible in meeting changing, competitive demands. The focus is on common concerns related to human resource development, and to identify possible solutions. Sector councils address a wide range of issues including recruiting and retaining workers, anticipating skills shortages, technological change, quality standards, planning and human resource development. They do not expect a single approach to address all the potential issues for all sectors of the economy; the demands are too varied.

This sectoral approach is pan-Canadian and is able to accommodate provincial structures within a pan-Canadian approach.

The sector councils are primarily funded by the Government of Canada through Human Resources and Social Development Canada. A strategic management framework is used to identify current and future requirements for human resource development that will enable the sector to become more globally competitive. Upon completion, stakeholders may choose to establish a permanent structure (a sector council) to address these human resource issues on a continuing basis. Sector councils are usually run by volunteers, often with support from Human Resources and Social Development Canada.

A requirement for becoming a sector council is an in-depth human resource study that identifies the present and future human resource requirements. In recent years, there have been a number of such pan-Canadian studies of individual professions in the health sector. Although these sector studies have been criticized by some actors in the system (including some governments) as furthering the analysis of HHR from inside professional silos, on balance it has to be admitted that the work they contributed to HHR planning was important. The nursing sector study *Building the Future*, the CMA's Task Force Two *A Physician Human Resource Strategy for Canada, Moving Forward: Pharmacy Human Resources for the Future*[37] and the Canadian Association of Occupational Therapists (CAOT) *Background Paper on Occupational Therapy Data: Sources, Utilization and Interpretative Capacity* have provided a better understanding of the complex human resource issues within these professions.

Other studies, including *In Critical Demand: Social Work in Canada* (2000) and the *Canadian Home Care Human Resources Study* (2003), helped lay the groundwork for the studies that followed.

5.2 Lessons for the Health Sector

The value of a sector council is that it provides a forum for collaboration, bringing all parties to the table to address issues. It helps break down silos and allows for communication across disciplines and jurisdictions. The process is as important as the content. Given the number of stakeholders within the health sector, sufficient attention must be given to ensure all groups have a voice and an opportunity to express their concerns.

However, any body that is established must not appear to challenge the authority of the provinces. Rather, there must be strong relationships developed with provincial and territorial representatives and they must have a say in the priorities and work of the organization.

5.3 Other Models in Canada

Several initiatives have been introduced in recent years to provide a platform for the extended coordination of several non-HHR themes. The models analyzed are not inclusive, but rather illustrate possible models for an HHR mechanism and help identify possible challenges that may crop up when setting up a pan-Canadian mechanism. The following Canadian models were analyzed:

- Canada Health Infoway
- Canadian Council on Learning
- National Collaborating Centres for Public Health
- Canadian Patient Safety Institute
- Canadian Agency for Drugs and Technologies in Health

Two options arise from the non-HHR models that represent various takes on a pan-Canadian approach to planning:

- Independent not-for-profit corporations (e.g. Health Infoway, the Canadian Patient Safety Institute and the Canadian Agency for Drugs and Technologies in Health).
- Collaborating/Knowledge Centres (e.g. National Collaborating Centres for Public Health and the Canadian Council on Learning): A series of networks are linked and coordinated through a central "hub." The networks are typically located in academic units or research institutes across Canada, and often dispersed along themes.[38]

There are various options around governance, although there are variations around the selection process. They may either be a mix of both appointed and elected members (e.g. Health Infoway) or appointed by the FPT Deputy Ministers of Health (e.g. Canadian Agency for Drugs and Technologies is appointed by the FPT Deputy Ministers of Health). It is important for these pan-Canadian mechanisms, given their mandates, to include various stakeholder groups within the overall governance structure. For example, the Canadian Patient Safety Institute is likewise governed by a mix of both elected and government appointed officials.[39] Advisory committees are also very popular because they provide needed advice from key stakeholder groups on issues pertinent to their mandate. This is furthered by the value placed on partnerships and collaboration between all pertinent stakeholders, including academics, governments, provider groups, end users or clients, businesses, etc. The mechanisms for engagement include regular national consultations to identify health policy and research priorities, and an annual symposium.[40]

There are also few variations along accountability structures; most use the format of audits and annual reports. One of the most comprehensive accountability structures is that used by Canada Health Infoway, which incorporates annual financial audits, annual reports that include performance results relative to the corporate business plan, an annual compliance audit and a third-party evaluation.

The Canadian mechanisms are often funded by the federal government, although some, such as the Canadian Agency for Drugs and Technologies in Health, are also funded through FPT partnerships. The tenure of the funding is also critical. One respondent noted that there needs to be at least a five-year renewable grant put into place in order to get any pan-Canadian mechanism off the ground.

Finally, the key informants raised some key areas for the success of a pan-Canadian approach. First of all, it is important to put together a strategic business plan, being clear about targets and what actions can be taken to meet this plan. Secondly, the success of an organization of this sort requires that someone take emotional ownership of it – that is, a champion or leader who is willing and able to take charge of the organization and its mandate.

The third ingredient to success is relationship building and collaboration between all pertinent stakeholders, including academics, governments, provider groups, end users or clients, businesses, etc.[41] On this note, one key informant offered some practical advice

for implementing a pan-Canadian approach: "What is important is that you get out there, have clarity and delivery on messages, but don't try to do it all by yourself. Part of the problem I see with national bodies is that they try to do things all by themselves and not engage the various relevant groups out there." One does need to be aware of the differences in resources available to stakeholders. Smaller jurisdictions, for example, may have an interest and a stake in being involved in a pan-Canadian organization, but may not have the financial or human resource capacity to do so.

5.4 International Models

There are many activities going on at the international level that Canadians can draw on when setting up an overall HHR planning mechanism. A scan of international activities has shown several interesting initiatives at various stages of development, implementation and with varying degrees of success. We reviewed the following models: three that typify inter-regional alliances; two that represent other national approaches; and one that represents a provider-specific approach to HHR planning:

- The PAHO Latin America and Caribbean Observatory of Human Resources in Health
- Asia Pacific Action Alliance on Human Resources for Health (AAAH)
- The African Health Workforce Observatory
- NHS Scotland's "Working in Health"
- The American Bureau of Health Professions
- The International Centre for Human Resources in Nursing

Our final list is not inclusive because the search was conducted in English. The list serves rather as an illustration of international responses to HHR issues. We supplemented the literature review with electronic interviews with three key international informants.

The international and national models represent a wide mix of possible models for consideration for a permanent HHR structure. It is difficult to say what the funding period is for some of the interregional and interprofessional models because most of them, with the exception of the Pan American Association of Health Organizations (PAHO) Observatory of Human Resources in Health, which has been evolving since 1999, are relatively new to the scene. All the same, what they point to is a commitment by other jurisdictions, in varying degrees, to developing networks and partnerships between and within with member countries, and partnership building between relevant stakeholders including governments (which includes ministries of education), academics, civil society, etc, through information sharing, forums and clearinghouses. In short, Canada is not alone in the desire to take the next step in setting up a permanent mechanism to promote and address HHR planning issues. While there are some areas, such as financing and governance, which may not be directly transferable to the Canadian context, there is much that Canada can learn from the experiences of international and national endeavours.

As in Canada, heightened sensitivities and realities around the mobility of health professionals and the resulting shortages in specific countries or regions have led to a search for common solutions. One international respondent, for example, noted that the member countries adopted the interregional mechanism because they were all facing the same HHR challenges including shortages, poor distribution and concerns over productivity, accreditation, data quality and low motivation. There are also immediate issues, such as pandemics and the migration patterns of providers, which have called for a unified and rapid response. According to the key informants, the benefits accrued to a collaborative inter-regional approach include: joint advocacy actions; sharing knowledge and tools; and coordinated HHR knowledge management and capacity building through regional workshops and shared Web resources.

The interregional approaches often represent a network of member countries with their own HHR issues, which are connected, often loosely, through a central organization, or persons. The Asia-Pacific Action Alliance on Human Resources for Health, for example, is an informal network of 15 countries,[42] the activities of which are coordinated by a two-person secretariat team.[43] An Asia-Pacific Alliance steering committee oversees the function of the Asia-Pacific Alliance secretariat and provides guidance and recommendations on the activities to be carried out by the Alliance members.

Likewise, the PAHO Latin America and Caribbean Observatory of Human Resources in Health coordinates the activities of 21 countries of the Region of the Americas around common HHR planning issues.[44] PAHO provides each member country with technical cooperation in collecting core data and identifying trends and international comparisons. Each member country has its own coordinating mechanism, which in turn reflects a variety of organizational options.[45] The accountability relationships within the PAHO Observatory depend on financing sources; however, usually the Ministry of Health and the PAHO representative have oversight over the activities.

While they are in various stages of implementation, the inter-regional HHR mechanisms address these common issues through sharing knowledge and tools, and coordinating HHR knowledge management and capacity building (e.g. regional workshops, shared Web resources, etc.). For example, the Asia-Pacific Alliance provides a common space for advocacy, information monitoring, knowledge generation and sharing, capacity strengthening and technical support to countries. These are translated into more specific actions, which include reviewing HHR health trends, collecting case studies on HHR and putting into place mechanisms for information sharing and best practices.[46]

Of critical importance to the interregional approaches is the participation and engagement of not only government representatives (which may include the ministries of education), but also professional organizations, universities and representatives of NGOs and civil society.[47] For example, the mechanisms for stakeholder engagement and networking by the PAHO Observatory include annual meetings, consultations and interchanges of experiences based on specific topics (e.g. nursing policies, staffing methods, career regulations and institutional capacity in the Human Resources Units). Member countries of the PAHO Observatory carry out a wide range of HHR activities,[48] which are

connected through the PAHO office in Washington through sub-regional meetings and a collective Web page.

We added to our analysis two national models: the American Bureau of Health Professions, housed in the Health Resources and Services Administration of the United States Department of Health and Human Services; and the NHS Scotland "Working in Health" interactive website. The Bureau has several components related to workforce planning including a Shortage Designation Branch and Practitioner Data Banks Branch.[49] Five regional HHR Centers are funded by a cooperative agreement with the National Center for Health Workforce Information and Analysis within the United States Health Resources and Services Administration's Bureau of Health Professions, to provide regionally based HHR information.[50]

A more "virtual" approach is taken by the NHS Scotland in their "Working in Health" interactive website. The website is part of an overall framework set out by NHS Scotland in promoting information sharing around workforce supply and demand and HHR planning strategies, which include the Student Nurse Intake Program (SNIP).[51] The following three main themes related to the overall HHR planning framework are outlined on the website:

- Culture and Behaviour, which describes the dynamics required for a healthy workplace (e.g. leadership development, values, team working, etc.);
- Supply and Demand, which provides information on HHR needs and capacity (e.g. labour market context, information systems, workforce planning, etc.); and
- Securing Change, which includes information on change management (e.g. workforce design, motivation, etc.).

What is interesting and useful in the approach by NHS Scotland is its comprehensiveness. Each theme, for example, often comes with its own searchable repository, which provides users with up-to-date information, data, manuals, tools and best practices.[52]

The International Council of Nurses (ICN) has implemented an International Centre for Human Resources in Nursing (ICHRN), which focuses on strengthening the nursing workforce globally through developing, ongoing monitoring and disseminating comprehensive information, standards and tools on nursing human resources policy, management, research and practice. This mandate is facilitated through a website with a knowledge library, a biannual newsletter, commissioned papers (e.g. country case studies or theme studies), published interviews with human resource experts, campaigns, tools and standards, and tools related to continuing education.

The challenges noted by the international stakeholders in both the development and ongoing activities of the HHR mechanism include the following:

- Finding a common ground on various aspects related to HHR planning without alienating any member countries;

- Identifying the right stakeholders/partners from each member country and securing their involvement;
- Securing necessary funding support for the operation, especially long-term financing; and
- Differing stakeholder agendas.

5.5 Observations

The scan of both Canadian models outside of the realm of HHR planning (many of which were still dealing with health care issues) and the international models of collaborative HHR planning mechanisms revealed a number of factors that are essential to their critical success:

- The presence of "champions;"
- Clearly articulated goals and mandate; and
- Collaboration between partners.

First is the issue of leadership and the presence of "champions" both governmental and non-governmental. While many of the international models are quite new, some of the Canadian models examined have what could now be considered to be significant track records in their field. What is common to both the successful launch of these models and their growth and maturation is the presence of key individuals and organizations that were prepared to invest resources – financial and human – to insure success. That investment, sustained over a number of years, is crucial to moving from one-off planning exercises to long-term results and for nurturing organizations and structures through the inevitable growing pains and conflicts that they will encounter.

At the same time, these models share a significant degree of clarity around their goals and mandates. This includes a significant amount of preparatory work in developing shared understandings of the proposed mechanisms, goals and mandate and the setting of reasonable expectations over what can and cannot be accomplished within reasonable time frames. Nothing can be more detrimental to the continued success of these kinds of mechanisms than going into the process with unrealistic expectations about what can be achieved and when. There are important competing interests that will have to be managed in these kinds of collaborations. That management takes not only dedicated champions, but also a willingness to understand and acknowledge that the competing interests and perspectives of the collaborating partners will need to be accommodated if the mechanism is going to be sustainable in the long run. In short, there is great value to be gained by insuring that the groundwork is properly laid and common understandings and expectations are shared.

Finally, these kinds of mechanisms are successful (or appear as if they will be in the future) only insofar as they operate in a truly collaborative manner. These models all tend to be inclusive rather than exclusive and dedicate significant time and energy to insuring that relevant partners all have a voice in operating the organization and an

appropriate level of involvement in assessing the work of the mechanism. Again, as we discuss in more detail later, one of the challenges that will be faced in developing a pan-Canadian, multi-professional HHR planning mechanism is the perception of some that they are perpetually on the "outside" when important activities are being planned. What makes some of the models discussed above successful is their commitment to inclusivity and collaboration among partners. This can make the early years of these organizations difficult and fraught with challenges, but is a necessary component of building trust among the actors involved.

6. Findings from the Key Informants and the Electronic Survey

This section provides insights gleaned from interviews with key informants and a survey with health care stakeholders including health care providers, professional associations, regulatory bodies, the research community, students, employers, unions and governments.

The key informants interviewed for this study fell into to two broad camps. First were government officials from the federal, provincial and territorial governments. Most of these were members of the FPT Advisory Committee on Health Delivery and Human Resources (ACHDHR) or the ACHDHR sub-committee on Human Resources Planning. Second were representatives from major health care stakeholder organizations representing specific health care professions (doctors, nurses and other health professionals) and other NGOs including employers, unions, educators and others with an interest in health care reform generally and often with a particular interest in HHR planning. Appendix I contains a list of those interviewed for this study.

Information was supplemented by the views obtained from a Web-based survey. Forty-four percent of respondents are health care providers of some form, and another 15% are representatives from professional associations. The third largest group of respondents came from the university community.

There appears to be a consensus on the need for better coordination between governments and stakeholders in HHR planning. But, again as noted above, that consensus appears to be around a fairly strong understanding of what the existing gaps and needs are when it comes to HHR planning, rather than what kind of mechanism might best serve in meeting those needs or filling those gaps. Here the division is pretty clear between the government officials and the representatives of the stakeholder community.

There were a couple of outliers that, while they are a distinct minority within the sample interviewed, their perspectives were so different from most others that it was felt that, at the very least, their views needed to be noted. For one respondent, the very idea of a pan-Canadian, multi-professional HHR planning mechanism was something of a pipe dream. Citing governmental reluctance to let stakeholders be actively involved in the process, combined with intergovernmental competition for scarce human resources, this respondent saw little real chance of moving forward on the creation of such a mechanism.

If the discussion of a pan-Canadian mechanism had any value, it was as a means to hold governments' and stakeholders' feet to the fire to make actual progress in their own areas of jurisdiction and competence. A second respondent expressed a concern that the discussion of a mechanism was taking place without a clear sense of "what difference it would make" in the end. For this person, all the effort at collecting data, disseminating best practices, coordinating research, etc. was ultimately beside the point if no-one acted to solve "the HHR crisis that is already upon us."

Again, these were the views of only two of the respondents interviewed and their pessimism was not shared by others. But it is worth noting that these kinds of views do exist within the health system leadership and that this fact in itself makes the need for some resolution of the question of whether there will or will not be progress on creating a mechanism more urgent.

6.1 Identifying the Needs and Gaps

In terms of identifying current HHR planning needs and gaps, there was a near universal identification of:

- Better and more comprehensive data:
  - Across professions, jurisdictions and from the private sector;
  - About population health needs;
  - Better integration of existing databases that are currently dispersed across governments and NGOs;
- Common data collection and reporting standards (i.e. comparability of data);
- More comprehensive simulation modelling of supply, demand and population health needs;
- Better capacity to share best practices within and across jurisdictions and better dissemination of leading-edge research in HHR planning;
- Better utilization of existing data and research in a format that can be used by policy planners and decision-makers; and
- Reduction of duplication of effort across jurisdictions, sectors and professional groups

In addition, a number of interviewees spoke of the apparent disconnect between actors in the system as one of the key factors to be addressed. This was true, for them, not only in terms of a disconnect or lack of communication between stakeholders and government decision-makers, but also within the policy-making realm where there was seen to be an ongoing lack of coordination or understanding between health ministries and post-secondary education ministries leading to either decisions that were unworkable or unrealistic when it came to dealing with the supply side of HHR planning. In addition, available information does not filter down to those most in need. For example, regional health authorities do not use existing sources of information and data when developing their own HR needs. Local organizations often work at cross purposes, rather than collaborating to find a common solution.

A number of respondents from both the stakeholder/NGO community and governments took pains to note that the state of the data in Canada has been steadily improving in recent years and that the existing data collection and dissemination infrastructure is getting better. So whatever shortcomings still exist (and that they do, there was no doubt), it is worth stressing that we have access to much better data now than was the case a decade or two ago, albeit primarily only for physicians and nurses. There remain very large gaps in our data resources as they apply to those professions that operate either in both the public and private system or entirely in the private sector.

Indeed, a number of the key informants went further in this analysis by saying that whatever mechanism might be created, it should not try to either supplant or duplicate the work currently being undertaken by the Canadian Institute for Health Information (CIHI). Having gone through some significant growing pains in its first years of operation, these informants were highly complementary towards the work that CIHI is currently doing, noting that CIHI's reporting is more robust, more comprehensive and more comparable than it ever has been. Thus, for them, the concern was that some HHR planning mechanism could potentially undercut CIHI's progress (e.g. by taking over some of its functions) or needlessly duplicate its efforts when resources could be used by CIHI to further improve its work. As one informant put it "leave the data collection and initial analysis to CIHI, it is their job and they doing it better than anyone at this point."

6.2 Identifying the Challenges

The first point of departure between the stakeholder/NGO respondents and the government officials came when they were asked about the potential challenges to creating one or more pan-Canadian, multi-professional HHR mechanisms. At or near the top of the list of the challenges for the stakeholder community were governments themselves. Seventy-three percent of survey respondents felt that the perceived intrusion into provincial areas of responsibilities presented a challenge to any pan-Canadian HHR planning mechanism. Respondents noted the overly politicized nature of the FPT environment, in which HHR planning discussions were held, as a major stumbling block to making progress. As a result, progress often was based on a lowest common denominator rather than on making substantial process. NGO respondents referred to governments being preoccupied with jurisdictional issues at the expense of making progress on more coordinated HHR planning. That being said, government officials pointed to some clear successes in developing shared strategies in some areas (e.g. the role of internationally educated medical graduates). It may well be that the sometimes fractious politics of higher-level intergovernmental negotiations obscures some of the successes achieved.

Some of the stakeholder/NGO respondents went even further in their criticism of government. These respondents spoke of a frustration with what they perceived to be as the relatively closed-door environment of the intergovernmental processes – including those processes involved in creating the pan-Canadian HHR Planning Framework – where the stakeholder sector was only invited into the discussions after the governments had come to an agreement. These respondents spoke of what they perceived as an adversarial

perception of them by governments or, as one respondent noted, "It's like they're afraid of us." And one went so far as to note that, "We [the NGO community] are tired of waiting for our invitation to participate."

A common concern was expressed by a respondent who noted that "these things tend to become just another level of bureaucracy that is large and growing without any actual improvement."

On the other hand, government officials have real concerns about opening up a process to include actors that are not accountable for financing and managing the system. Health care is the single largest government expenditure in every jurisdiction. This in itself is a preoccupation of most governments. Demands for changes in HHR policy that come with little or no consideration given to their impact on system costs (e.g. issues over entry-to-practice) are a key source of concern for governments' relations with the stakeholder community.

Respondents both through interviews and the survey also identified the challenge of breaking down the silos between health professions.

Government officials focused their concerns over the challenges of building a HHR planning mechanism on the fear that it would be perceived as yet another addition to the health care bureaucracy rather than as a key component of moving forward on the issues. There was a general concern that any mechanism that was created be seen as an advance by both the public and governments rather than as just another organization or body that governments will have to report to or prepare data for. Related to this was the concern that a separate HHR planning mechanism – especially one that took the form of some kind of specialized stand-alone operation – would further sub-divide the health care policy landscape in a manner that would be inefficient and, in the end, yield little in the way of results. At the same time, the respondents generally came back together when asked about how some form of an HHR mechanism could complement the work of governments and others. Here again there was a strong consensus that whatever form the mechanism (or mechanisms) might take, it should be carefully mandated in a manner that supports the ongoing work of both governments and stakeholders in this area. It was consistently spoken of as a "coordinating function," a "support function," "neutral space for conversation, discussion or debate," "a clearinghouse for information," etc.

More than 74% of the survey respondents identified ongoing sustainable funding as a primary challenge for any pan-Canadian HHR structure

6.3 Identifying the Mandate, Structure and Governance Possibilities

Where the most important divide between the stakeholder/NGO respondents and those from government begins, however, is when the discussion of the mechanism turned to issues such as mandate, governance and accountability. There was a tendency on the part of government officials to see the mechanism as part of the intergovernmental process of pan-Canadian HHR planning – as something that would work to assist governments in their deliberations, usually reporting to a FPT body such as the ACHDHR. Where there seemed to be a relatively strong consensus was that there was little enthusiasm for a fully-fledged separate organization in the mould of the Health Council of Canada. Over and over again respondents spoke about a smaller organization relying on networks of researchers, analysts, stakeholders and governments rather than a "bricks and mortar" solution that would try to bring the disparate elements of HHR planning, research and analysis under one roof. Indeed, rather than speaking of "roofs," the respondents tended more often to think of the mechanism as more of an umbrella.

For their part, the NGO/stakeholder respondents tended to conceptualize the structure of the mechanism somewhat differently. For them, there was a need for a body that would serve not only the efforts of governments, but also those of the stakeholder/NGO community. As such, these respondents tended to view the mechanism as something that would actively involve both governments and the stakeholder community both in its functions and in its governance and accountability. While there was some reluctance on the part of these respondents to speak of the mechanism as a large, multi-faceted research and dissemination organization, there was a clearer sense that they would prefer something that was more "free-standing" or "independent" than their government counterparts. Forty-five percent of survey respondents identified an independent, stand-alone, not-for-profit corporation as their preference. A similar number identified placing the proposed mechanism within an organization such as CIHI.

They tended to talk of a mechanism that was linked to both the FPT world of HHR planning as well as to the stakeholder/NGO community through some form of shared governance and accountability. By contrast, government officials tended to see the organization as more clearly a creature of the FPT structure, reporting to governments and as a place where stakeholder and NGO groups could access the FPT processes.

Still, it has to be admitted that both the government officials and the stakeholder representatives were at times frustratingly vague on the issues of governance and accountability. Where the conversation focused on structure and mandate, the respondents were more forthcoming. They spoke consistently of the need for an organization that was relatively small in terms of its permanent structure – with frequent reference to notions of a "network" of researchers and analysts supported by a relatively small permanent organization – and of one with a clearly carved out mandate that would serve as source of data, data analysis, expertise and synthetic research on best practices. It was generally conceived of as a "service" entity rather than as one that would carry out primary research or engage in policy advocacy for particular choices. For example, it could build HHR planning models and run simulation exercises on behalf of governments

or stakeholders, but it was not seen as something that would advocate that either governments or stakeholders behave in particular ways or make particular choices.

For government officials (and for some of the stakeholder organizations), there was a clear preference that the mechanism "starts small" and only grow after it was deemed to be a useful addition to the HHR infrastructure that already exists. Some were concerned that ADHDHR has started this work and is already linked to the provinces and to a lesser degree provincial stakeholders. This was expressed as "please don't interfere with the progress being made." The stakeholder/NGO respondents (and a couple of the government officials), on the other hand, tended to have a much more robust mandate in mind for any potential mechanism – running the gamut from data collection and modelling to trend analysis, setting common benchmarks and public reporting on progress.

Interestingly, it was the larger stakeholder organizations that had the most fully fleshed out ideas around the mechanism's governance. These respondents spoke very clearly about a mechanism that would be jointly governed by governments and stakeholders with the active participation of the research community (e.g. the Canadian Institutes of Health Research and the Canadian Health Services Research Foundation) and other NGOs in the health sector. For at least one stakeholder group, this would be accomplished by officially expanding the ACHDHR or its Health Human Resources Planning sub-committee to include these actors – referred to by some as "ACHDHR+." Alternately, they spoke of the mechanism as an entity that would serve as the research or analytical arm of something akin to a "health sector roundtable," which would include governments, stakeholders, NGOs and other interested parties – in effect a permanent forum providing neutral space for discussing HHR planning priorities. In both cases, the mechanism itself could be relatively small and serve as a secretariat for a broader-based network of researchers and analysts, coordinating and disseminating the "state of the art" in terms of data and analysis. What comes through is the very strong desire to expand the process to include representatives from the NGO community. But it is tempered by the recognition that this must be seen to be playing a role in the current structure.

Another potential model that was discussed by some respondents was to create the mechanism within an already existing organization. For example, creating a specialized secretariat within an organization, such as CIHI, that could build on CIHI's already substantial work in HHR planning, was one such model. It is interesting to note that there was little support for housing any new pan-Canadian mechanism within the existing structure or the mandate of the Health Council of Canada, which appeared to be the first choice in much of the literature on the issue before the Council was created following the 2003 and 2004 intergovernmental health accords.

With a couple of exceptions, there was little appetite expressed for an organization that would report directly to the public on issues related to HHR planning. Rather, the accountability of the mechanism was more commonly conceived of being to either governments (e.g. to the ACHDHR or its sub-committee) or to some combination of

governments and stakeholders. How this accountability was to be achieved was pretty consistently set out as a form of regular reporting on a clearly defined set of deliverables.

6.4 Financing the Mechanism

Again, there was little sense from either government or stakeholder interviewees about the kinds of resources that any mechanism might need. Given that many of the respondents had relatively clear ideas about the kinds of work that needed to be done by a HHR planning mechanism, but were less clear on the issues of its size, structure, governance or accountability, it is not surprising that they tended not to have a very clear sense of what it would cost to finance the operation.

Clearly, a mechanism consisting of a small secretariat reporting directly to ACHDHR and maintaining a network of researchers, analysts and advisors would be significantly less expensive than creating a fully-fledged, stand-alone entity with a broad-based research and reporting mandate. But other than that generalization, there was little sense of actual costs involved.

Both governments and stakeholders did tend to see governments, specifically the federal government, as the prime funder of any mechanism. Nearly 40% of survey respondents felt multi-year funding from federal, provincial or territorial governments would be the preferred approach. Clearly, though, governments see that funding as one of the key rationales for their preference for a reporting and accountability structure tied more closely to governments than to stakeholders or NGOs. However, that said, there was some willingness on the part of at least some of the stakeholder organizations to contribute to building the mechanism, either through direct funding or through in-kind services to the mechanism and its secretariat. Of course, the financial capacity of the health sector stakeholders varies considerably (as it does with the FPT governments). There was a clear recognition on their part that dollars could not be a determinant of voice in operating the mechanism. Indeed, there was a clear recognition from the larger stakeholder organizations that there was a need to insure the participation of the smaller organizations, regardless of their financial capacity.

In developing the options to be considered, then, we have had to rely not so much on the interviews and the survey conducted, but rather on some of the existing work on potential models to develop some sense of the kinds of financing a mechanism might need. This work is noted in the final section of the paper.

6.5 Observations

What comes out of all of this discussion of mandate, structure, governance and accountability is that while there is still strong support for some kind of mechanism (and respondents very rarely talked about more than one), there are somewhat divergent views on what that mechanism could or should look like. The respondents' views diverged on:

1) How broad the mandate of the mechanism should be;
2) How it could be structured to add to the HHR planning infrastructure without duplicating already existing elements of that infrastructure;
3) Whether it should be governed jointly by governments and the stakeholder/NGO community; or
4) Whether it should formally be integrated into the existing FPT infrastructure while more actively consulting and engaging with stakeholders.

If the interviews revealed anything about the current state of the debate over the need for a pan-Canadian, multi-professional HHR planning mechanism, it was that, conceptually at least, all parties tended to agree that the current situation in the country argues for the issue to be considered again by governments and the stakeholder community. As the literature review noted, there was, in the aftermath of the Romanow and Kirby reports and following the 2003 and 2004 intergovernmental accords, some significant interest in moving forward on the issue. For whatever reason, those efforts came to nothing.

At the same time, there has been in recent years much more collaboration both among stakeholders and among governments on HHR planning issues. Thus, the environment in which a mechanism would be created may be more receptive. Governments seem at least willing to entertain the notion again insofar as they themselves feel that their own work on the Pan-Canadian HHR Planning Framework has put them in a position where they see more value in some kind of mechanism that could begin to help them operationalize the commitments contained in the Framework.

Thus, at the very least, there is a willingness on the part of all parties to perhaps take up the conversation from before. To be fair, as we have already said, the exact level of enthusiasm is quite varied, but there does appear to be enough of a common denominator to make the engagement of that conversation worthwhile. But as a final cautionary note on the interviews, it should be said that for some of the stakeholder/NGO community, there is a growing sense of frustration with governments' apparent unwillingness so far to re-initiate that conversation – a frustration that led one respondent to speak about a "last chance" to engage with governments in a constructive manner before looking for alternative solutions.

7. Options for Consideration

Both governments and the stakeholder/NGO community appear ready once again to engage in a discussion that would improve HHR planning in this country. The challenge lies in the fact that, as is obvious from the key informant interviews and the electronic survey of stakeholders, there is still no overwhelming consensus about the mandate of any pan-Canadian, multi-professional HHR planning mechanism.

Without a relatively clear sense of what the mechanism or mechanisms would do, it is difficult to come to grips with exactly what kind of structure is needed, how that structure would be governed, how accountability would be achieved and how (and to what level) that mechanism would be financed. Form should follow function.

That being said, it is possible to take from the interviews and the survey some sense of a mandate that would at least be acceptable as a starting point for most of the participants. And the international experience with a variety of mechanisms provides further insights into what could be taken at the very least as a starting point for a pan-Canadian, multi-professional HHR mechanism. What follows then, is, for want of a better term, something of a minimalist mandate for a HHR planning mechanism that could serve as starting point for consideration of the options that follow in terms of governance, accountability and financing.

7.1 Principles Guiding Option Development

The first principle that needs to be acknowledged is that the mechanism must be complementary to the rest of the HHR planning infrastructure that currently exists in the country. In particular, if the mechanism is to have governmental support – which is crucial for having any serious impact on policy – the mechanism must have some relationship, formal or informal, to ACHDHR. In short, it must have a link to the intergovernmental processes that are so much a part of HHR planning in the country. Thus, as was noted by some of the respondents in the interviews, the mechanism should not involve itself in activities where other organizations already have a clear advantage in terms of capacity, resources and support. It makes little sense to play a significant role in the collection of primary data or in its initial analysis. This is a role currently being undertaken by CIHI. There is a significant sense that CIHI's performance as the key clearinghouse for health data in the country is continuing to improve. To the extent that CIHI itself might need to further invest in its own capacity to continue that improvement and to fill the kinds of data gaps that are noted in the literature, by the stakeholders, the NGOs and governments, then that would appear to be a more prudent course rather than trying to invest a new HHR planning mechanism with such a mandate.

Secondly, the mechanism needs to be structured in such a way that it respects the role of the various actors within the system in a manner that allows governments and stakeholders to continue to be the key developers of policy and decision-making when it comes to HHR planning. The mechanism needs to refrain from policy advocacy, but rather should be positioned as a neutral resource for stakeholders/NGOs and governments

that informs the policy discussions between governments, between stakeholders and between stakeholders and governments. To the extent that the mechanism attempts to substitute its judgement for that of the actors that actually govern the health system and that are accountable to their own publics, then it will run the risk of alienating the very actors it seeks to support.

Thirdly, there is a clear need on the part of some governments and many of the stakeholder/NGO organizations for increased capacity to use the existing data to develop better HHR planning models both in geographic terms and across professions. Thus, a mechanism with some capacity (either in-house or via a network of relationships with other expertise) to assist in developing and testing models rooted in population health needs would be of significant service to all actors within the system.

Fourthly, both the stakeholder/NGO community and governments have a clearly expressed need to understand better the policy developments (and their impacts) in other jurisdictions across the country. It is a virtual truism of health policy developments in this country that governments and other actors have very little capacity to consistently and coherently understand the implications of developments occurring in other parts of the country. Although, in fairness, this capacity has improved in recent years (e.g. on the issue of wait time and wait list management), a mechanism charged with both identifying best practices and extracting policy lessons from those practices would provide governments and stakeholders with an invaluable element of HHR planning.

Finally, it is clear that there remains some level of tension between governments and stakeholders in terms of how they each view the other's role in HHR planning. Some stakeholders and NGOs are clearly frustrated with what they see as their lack of voice in the policy development and decision-making processes of governments. They see themselves as "outside looking in" and as "waiting for an invitation to participate." Governments, for their part, see HHR planning as, ultimately, their responsibility as both the funders and administrators of the public health care system and as being the entities that are ultimately accountable to the Canadian public for both its problems and its successes. In their view, the buck, both literally and figuratively, stops with them. But clearly successful HHR planning on a pan-Canadian, multi-professional level will require a more engaged and sustained dialogue between governments and stakeholders (and eventually with citizens themselves). As such, there needs to be a neutral space where these actors can come together in an environment that fosters open dialogue, honest disagreement and mutual respect. The international examples of such mechanisms examined as part of this study clearly demonstrate that such forums can be successfully developed in a manner that serves the interests of multiple jurisdictions. Furthermore, if stakeholders want to assume a greater role in HHR policy development in collaboration with governments, they will need to assume some responsibility for the outcomes of the policy choices made as a result of that collaboration.

In summary then, the mechanism's key focuses should be on:

- Synthesising and analysing existing data and data sets;
- Synthesising existing research in HHR planning on behalf of actors within the system;
- Serving as a clearing house on best practices for both governments and stakeholders;
- Serving as a developer of needs-based interprofessional HHR planning models on behalf of governments and other actors; and
- Serving as a neutral forum for system actors to engage in open discussion and assessment of HHR planning policy options.

What follows are sketches of three different options for consideration. Each attempts to adhere to the principles outlined above. The three share broadly similar mandates in terms of functions – although they differ on how those functions are carried out to some degree. The key differences lie in the governance, accountability and size of the different models. There are other permutations that are possible and elements from one model could be adapted to other models.

Most importantly, these models are presented in an effort to focus the discussion between governments and stakeholders in a manner that will move us away from the highly abstract concept of "there should be a mechanism" and toward a more constructive engagement with the notion of "what that mechanism should look like."

7.2 Proposed Options

The possible options for the structure, governance and accountability relationships that might be conceived for a pan-Canadian mechanism are many. The table below summarizes three distinct but inter-related models that stem from the assessment of what the mechanism would need to do to serve the interests of governments, stakeholders and the research community and draws on the outline of both the existing HHR planning infrastructure in the country and the existing models for similar endeavours in the international arena. The three possible models can be described as:

1. **The FPT Secretariat:** A mechanism that is directly accountable to ACHDHR with an advisory role for the stakeholder community.
2. **The Embedded Secretariat:** A mechanism formally embedded within an existing research/policy organization reporting to that organization and with ACHDHR and the stakeholders playing an advisory role.
3. **The Co-Governance Model:** A mechanism that is directly accountable and reports to an expanded version of ACHDHR, which includes representation from the stakeholder community (referred to by some of the key informants as "ACHDHR+").

Although the activities of the three models are broadly similar and are built on the understanding of where the common ground lies between governments and stakeholders on this issue, the real differences between the three models lie in their structure, governance and accountability. In Models 1 and 3, the mechanism is directly

accountable and reports to either ACHDHR (Model 1) or to ACHDHR+ (Model 3). In Model 2, however, the mechanism is directly accountable to the organization in which it is embedded, whether that is an organization such as CIHI or the Canadian Institutes of Health Research (CIHR) or some other body. In this model, both ACHDHR and the stakeholder communities have an "advisory" role in terms of agenda setting and research/analytical priorities.

There is a second-order question for Models 1 and 3 as to where they might be physically housed in order to provide them with some infrastructure to support their work. Each could be housed within a government department (e.g. Health Canada), but with clear reporting to ACHDHR or ACHDHR+. Alternately, they too could be housed within another organization, such as CIHI or CIHR, for infrastructure support, but they would not be part of those organizations in terms of their reporting and accountability relationships. The difference here is in the distinction between "housing" the mechanism in an organization and "embedding" it in an organization. If the mechanism is embedded inside an existing research/policy organization, it becomes a formal part of that organization with all of the accountability and reporting relationship that this implies.

Admittedly, there remains some "fuzziness" around the edges of each of the models outlined, but this inevitable insofar as there are detailed elements of the structure, mandate, accountability and reporting relationships that can only begin to be worked out once there is an agreement to actually build the mechanism. They are provided, therefore, as an attempt to delineate three somewhat distinct options that can serve as the starting point for a conversation. That the result of such of a conversation would likely be the development of some hybrid from among the options would not be unexpected.

Summary and Overview of HHR Planning Mechanism Models

	Model 1: A FPT Planning Secretariat	Model 2: Secretariat Embedded in Existing Organization	Model 3: Co-Governance Model
Structure and Activities	A small secretariat designed to facilitate and coordinate the activities of a larger network of researchers and analysts • Linked to existing HHR planning research clusters • Facilitates development of additional clusters • Facilitates meetings and forums involving governments, researchers and stakeholders • Synthesizes and disseminates data analysis, research and best practices • Identifies and coordinates modelling and simulation activities on behalf of governments and stakeholders • Could be housed within a government department or within another independent research or policy organization	A small secretariat within an existing research/policy organization • Secretariat lead with small support staff • Small specialized in-house staff • Data and research synthesis and analysis carried out in-house • Facilitates specialized research/projects on behalf of governments and stakeholders	A small secretariat designed to facilitate and coordinate the activities of a larger network of researchers and analysts • Linked to existing HHR planning research clusters • Facilitates development of additional clusters • Facilitates meetings and forums involving governments, researchers and stakeholders • Synthesizes and disseminates data analysis, research and best practices • Identifies and coordinates modelling and simulation activities on behalf of governments and stakeholders • Could be housed within a government department or within another independent research or policy organization

	Model 1: A FPT Planning Secretariat	Model 2: Secretariat Embedded in Existing Organization	Model 3: Co-Governance Model
Governance	Mechanism reports to ACHDHR (or sub-committee) Served by an Advisory Council of stakeholder/NGOs Agenda for the secretariat set by ACHDHR in consultation with the advisory council	Mechanism formally reports to the research/policy organization in which it is embedded Served by an Advisory Council of ACHDHR and stakeholder representatives to provide advice on agenda setting and research priorities Reports/research products are issued under auspices of the research/policy organization	Mechanism reports to an expanded ACHDHR (or sub-committee) that includes significant stakeholder representation (ACHDHR+) ACHDHR+ sets agenda and priorities with some flexibility for independent analysis
Accountability	Regular reporting to ACHDHR through specialized activity reports Advisory council provides ongoing feedback on activities	Specialized reporting on HHR planning issues through home organization's established reporting mechanisms	Regular reporting to joint governing body Specialized reporting as required
Funding	Funds for the secretariat provided by governments through ACHDHR Advisory council provides in-kind services (including professional interchanges for the secretariat) Network partners funded for specific projects and through research grants from academic and other sources	Additional resources to organization for operations of the secretariat (most likely from government) In-kind services from stakeholders Funding for specialized research/analysis/modelling from governments or stakeholders	Secretariat funded by governments In-kind services provided by stakeholders/NGOs

	Model 1: A FPT Planning Secretariat	Model 2: Secretariat Embedded in Existing Organization	Model 3: Co-Governance Model
Strengths	Small organization, relatively inexpensive to operate Leverages existing expertise and builds relationships across the country Provides a voice for stakeholders while preserving jurisdictional autonomy of governments	Builds on the existing strengths of organization as key component of the HHR planning infrastructure Relatively small resource requirements Independence from both governments and stakeholders	Small organization, relatively inexpensive to operate Leverages existing expertise and builds relationships across the country Clear voice provided for stakeholders in HHR planning
Weaknesses	Potentially unstable insofar as networks difficult to both build and maintain May have difficulty responding quickly to specific tasks with little in-house capacity Research funding not guaranteed and reliant on priorities of funding agencies	Limited voice for stakeholders and governments in the agenda setting Limited capacity to build linkages with existing research clusters or to facilitate new clusters Creates differentiated governance structures and mandate within organization Asymmetrical structure difficult to sustain May become “lost” within the dominant organization	Potentially cumbersome and large governance structure Could be difficult to determine who is and who is not part of governance Could be difficult to set clear agenda Governments could perceive a dilution of their jurisdictional authority

7.3 Conclusions

It is evident from the interviews and the survey that there is significant support to create some kind of pan-Canadian, multi-professional HHR planning mechanism. In addition, it is clear from the international scan that other nations are already some ways down this path. However, one must always be careful about any attempt to transplant ideas from elsewhere in that there are some peculiarities about the structure of the Canadian health care system that need to be taken into account. While Canada is by no means the only federal state struggling to deal with HHR planning, it should be acknowledged that the governance and accountability of Canada's health care system is more decentralized than that of any other federal state we examined.

This decentralization poses some specific challenges that have to be overcome in designing a HHR planning mechanism. Some of this is evident in reviewing the existing HHR planning infrastructure. Indeed, one of the challenges is determining what should or should not be considered part of the infrastructure. A literal definition of infrastructure would imply some degree of permanence to an organization. But that would then exclude the important work accomplished by the sector studies undertaken over the past decade regarding not only nurses and doctors, but also a number of other health professions as well. Yet, those sector studies and indeed a number of the things reviewed are not permanent, but are significant one-off undertakings meant to inform and guide the subsequent debate and as such need to be seen as having contributed in some important way to understanding the challenges and potential solutions facing HHR planning in the country.

So, while there is support for something that builds on the progress that has been made by governments, NGOs and stakeholders in getting a better handle on both diagnosing the HHR challenges and articulating their potential solutions – something that would both consolidate current progress and coordinate future analysis – that support is much stronger in the stakeholder/NGO community than it is in the governmental community. Governments are understandably concerned about their jurisdictional autonomy and express more reservations about a mechanism straying into areas of policy advocacy. Thus as we noted above, as one probes the actors about a planning mechanism's mandate, structure, governance and accountability, there is far more variance in the levels of support expressed. While there is a general sense that stakeholders/NGOs are looking to something that might be more "robust" and which would give them a greater voice in the discussions, governments tended to see a much smaller mechanism integrated into existing FPT HHR structures. However, even then, there were some important variations within both of those so-called camps.

The mandate for a pan-Canadian, multi-professional HHR planning mechanism and the options outlined for its structure reflect an attempt to find some common ground among the actors. It is probably fair to say that none of the options would likely achieve a ringing endorsement from all the actors involved. Each of the options has elements that are both attractive and potentially problematic. Each involves some trade-offs between the competing values expressed by the actors in both the interviews and the surveys –

between respect for jurisdictional autonomy and wider engagement with stakeholders, between the risk of duplicating ongoing efforts and the risk of a mechanism that lacks strong links to the policy-makers in the system, between the challenge of sustaining substantive activity through dispersed, virtual networks and the wish to avoid building another large free-standing entity in an already crowded environment.

None of these trade-offs are necessarily a zero-sum prospect where progress on one definitely means a loss on another. And indeed the three options outlined above are really meant to be the beginning point of a more sustained conversation about how governments, stakeholders and NGOs can move forward in making the prospect of a new HHR planning mechanism a reality. There may well be some hybrid model that can emerge from these discussions that might be more satisfactory to more of the players.

But the key point is that there is, right now, a willingness to at least re-enter the conversation about the need for a pan-Canadian mechanism of some sort (although some are more tentative about that than others) and that should be seen as encouraging. Policy decisions come about, as Kingdon argues, through the intersection of ideas, interests and institutions that combine to create a window of opportunity for policy innovation. From our analysis it seems apparent that the idea's validity remains strong. There are strong interests aligned around the idea and some willingness of the institutional structures to engage on the issue. The question remains whether these can be harnessed in a manner that will result in an open window.

Appendix I. Key Informants Interviews

List of Key Informants Interviewed

1. Lucille Auffrey, Canadian Nurses Association
2. Jeanne Besner, Health Council of Canada
3. Bonne Blakely, Saskatchewan Health
4. Pamela Fralick, Canadian Physiotherapists Association and HEAL
5. Peter Gibson, Western and Northern HHR Planning Forum
6. Terry Goertzen, Workforce Policy and Planning, Manitoba Health, Government of Manitoba
7. George Gritzosis, Canadian Construction Sector Council
8. Piya Hanvoravongchai, Asia-Pacific Action Alliance on Human Resources for Health
9. Phil Hassen, Canadian Patient Safety Institute
10. Bentley Hicks, Health Canada
11. Ruby Jacobs, Six Nations Health Services
12. Mireille Kingma, Nursing and Health Policy, International Council of Nurses
13. Lisa Little, Canadian Nurses Association
14. Jeff Lozon, Canadian Partnership Against Cancer & St. Michael's Hospital, Toronto
15. Winston Maharaj, Health Workforce, Government of Manitoba
16. John Maxted, College of Family Physicians of Canada
17. Gail Tomblin-Murphy, School of Nursing and Department of Community Health and Epidemiology, Dalhousie University
18. Dora Nicinski, Atlantic Health Sciences Corporation, New Brunswick
19. Andrew Padmos, Royal College of Physicians and Surgeons of Canada
20. Felix Rigoli, Human Resources for Health Unit, Health Systems Strengthening Area – HSS/HRH Pan American Health Organization / World Health Organization
21. Francine Anne Roy, Canadian Institute on Health Information
22. Michele Roussel, Department of Health, New Brunswick
23. Jill Sanders, Canadian Agency for Drugs and Technologies in Health
24. John Service, Director, Canadian Psychological Association
25. Judith Shamian, VON Canada
26. Sharon Sholzberg-Grey, President, Canadian Healthcare Association
27. Linda Silas, Canadian Federation of Nurses Unions
28. Warren St. Germaine, Department of Health and Social Services, Northwest Territories
29. Lyne St. Pierre-Ellis, Department of Health, New Brunswick
30. William Tholl, Canadian Medical Association
31. Pamela Trainor, Department of Health and Social Services, PEI
32. Ben Van Den Assem**,** Department of Health and Social Services, Government of Nunavut
33. Nick Wise, Human Resources and Skills Development Canada (also in attendance: Erik de Vries, Stephanie Yung-hing, Kathleen Walford, Heidi Bungay, and Michel Doiron)
34. Wendy Swedlow, Canadian Tourism Human Resource Council
35. Glenda Yeates, Canadian Institute on Health Information

Notes

[1] Kingdon, John W. 2003. *Agendas, Alternatives and Public Policies*. 2nd ed. New York: Longman's.

[2] Deber, Raisa. 2004. "Delivering Health Care: Public, Not-for-Profit or Private?" in Gregory P. Marchildon, Tom McIntosh and Pierre-Gerlier Forest (eds.). *The Fiscal Sustainability of Health Care in Canada (The Romanow Papers, Volume 1).* Toronto: University of Toronto Press. pp. 233-296.

[3] HDP Group, Inc. and Brown Governance. n.d. "Within Our Grasp: A Study of Options for Establishing an Integrated Pan-Canadian Health Human Resources Planning Mechanism." Unpublished report prepared for Health Canada. Ottawa.

[4] Mable, A., and J. Marriott. 2002. *Steady State: Finding a Sustainable Balance Point: International Review of Health Workforce Planning.* Retrieved November 27, 2006, from www.hc-sc.gc.ca/hcs-sss/alt_formats/
hpb-dgps/pdf/pubs/2002-steadystate-etatstable/2002-steadystate-etatstable_e.pdf. p. 49.

[5] The website for the Kirby Report is: www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/rep-e/repoct02vol6part4-e.htm#CHAPTER%20ELEVEN. Retrieved June 4, 2007.

[6] Fooks, F., K. Duvalko, P. Baranek, L. Lamothe, and K. Rondeau. 2002. *Health Human Resource Planning in Canada: Physician and Nursing Workforce Issues*. Canadian Policy Research Networks.

[7] Fooks et al. also stipulate that regardless of the structure taken, an endeavour of this sort will require both federal and provincial support and will need to ensure that all policy stakeholders are involved in the organization. The operations of the mechanism also need to be transparent through public reporting mechanisms.

[8] Tomblin Murphy, G., and L. O'Brien-Pallas. 2004. "How Do Health Human Resources Policies and Practices Inhibit Change? A Plan for the Future.", *Changing Health Care in Canada: The Romanow Papers, Vol III*, Pierre-Gerlier Forest, Tom McIntosh and Gregory P. Marchildon, eds. Toronto: University of Toronto Press, pp. 150-182.

[9] Romanow Commission. 2002. *Building on Values: The Future of Healthcare in Canada*. p. 108.

[10] Task Force Two. 2006. *A Physician Human Resource Strategy for Canada: Final Report*. p. v.

[11] Med-Emerg Inc. 2006. *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada: Phase II Final Report.* p. iii.

[12] The Health Action Lobby. 2006. *Core Principles and Strategic Directions for a Pan-Canadian Health Human Resources Plan.* Ottawa: HEAL.

[13] Canadian Healthcare Association. 2006. *Human Resources in the Canadian Health System: Issues and Recommendations.* Canadian Healthcare Association's Policy Brief on Employability Issues Presented to the House of Commons Standing Committee on Human Resources, Social Development and the Status of Persons with Disabilities. Ottawa: Canadian Healthcare Association.

[14] Fooks, C. et al.

[15] A Physician Human Resource Strategy for Canada (Task Force Two). 2006. *A Physician Human Resource Strategy for Canada: Final Report.* Ottawa: Task Force Two.

[16] Fooks, C. et al.

[17] The Health Action Lobby.

[18] Task Force Two. p. 21.

[19] The Federal-Provincial-Territorial Advisory Committee on Health Delivery and Human Resources. 2005. *A Framework for Collaborative Pan-Canadian Health Human Resources Planning.* Ottawa: Health Canada.

[20] It should be noted that the role the Health Council of Canada plays as part of the "infrastructure" of HHR planning in Canada is limited. Although both Romanow and Kirby saw a council as a key player in monitoring and sharing best practices in HHR planning across the country, the current Council has had only a minor role in this regard. It has attempted to facilitate increased dialogue among researchers and policy-makers on HHR issues (e.g. a national consultation conference on HHR was held in 2005), but it has not been able to sustain much in the way of momentum in this area. At the same time, there is some obvious disagreement among the members of the Council over what its role and mandate should be. For some, the Council's activities should be limited to the specific commitments of the health accords while others have pushed for the Council to take a broader role in overall system monitoring, research, analysis and reporting to Canadians. At present, the Health Council is

undergoing a comprehensive review as it approaches the expiry of the health accords. The outcome of this review will likely determine its future mandate, but its overall contribution to HHR planning from a pan-Canadian perspective appears unlikely to change significantly in the future.

[21] In 2002, the federal government introduced the Canadian Taskforce on Licensure of International Medical Graduates (IMGs) to address the barriers to integrating IMGs into the Canadian health system. In 2005, the Internationally Educated Health Professionals Initiative (IEHPI) was likewise introduced to address the issues related to the successful integration of internationally educated physicians, nurses, medical laboratory scientists, medical radiation technologists, pharmacists, physiotherapists and occupational therapists.

[22] At the September 2004 First Ministers Meeting, the federal government announced it would be allocating $100 million over the next five years towards an Aboriginal Health Human Resources Initiative (AHHRI).

[23] The funding for the Forum comes from pooling a proportion of the individual funds provided to provinces and territories for HHR planning activities by the federal government.

[24] The Atlantic Deputy Ministers for Health and Education established the Atlantic Health Human Resource Association (AHHRA) to direct regional HHR planning, and set the scope of the study to include 30 health provider groups. A steering committee of representatives from the ministries of Health and Education was established in each of the Atlantic provinces. The following are the objectives of the integrated approach being taken by the AHHRA:

- Providing a "point in time" roll-up of provincial data into an Atlantic database;
- Reporting on HHR trends, issues and needs for education/training at the Atlantic level;
- Creating an inventory of basic and continuing education/training programs for selected health disciplines;
- Analyzing production capacity to meet current and future Atlantic education and training requirements; and
- Providing decision-makers with a clearer understanding of what information is (and is not) available.

The Atlantic Health Human Resource Planning Association recently completed an Atlantic Health Human Resource Planning and Simulation Model Study and Simulation Model, the goal of which was to carry out a comprehensive investigation of the regional requirements for health professionals in Atlantic Canada, and the regional requirements for available educational/training programs in and outside Atlantic Canada.

[25] Health Human Resource Strategies Division of the Health Care Policy Directorate of Health Canada. 2006. "The Western & Northern 'Forum' Real Collaboration, Real Result." In *Health Human Resource Connection*. Retrieved on March 30, 2007, from www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr-rhs-conn/2006-hhr-rhs-conn_e.pdf.

[26] The activities of the CHSRF include knowledge exchanges, research, funding opportunities and capacity development. One component of this is the Nursing Human Resources Knowledge Network, which provides a forum for information exchange between researchers, decision-makers, and stakeholders in nursing and nursing-related human resource activities across Canada. Canadian Health Services Research Foundation website. Retrieved on March 30, 2007, from www.chsrf.ca/research_themes/workplace_e.php.

[27] Canadian Policy Research Networks is a non-for-profit, independent policy research think-tank headquartered in Ottawa. It designs and undertakes research initiatives with funding support from governments (federal, provincial and municipal), local, provincial and national stakeholder organizations as well as from private sector sponsors. Health Human Resource Planning is one of the priority research themes under CPRN's Health Policy theme. CPRN has completed projects on a wide array of issues related to HHR planning, including ethical recruitment, access to care, nursing mobility and quality health care workplaces.

[28] Through an ongoing national consultation (currently going through its third iteration), the CIHR has identified HHR and HHR planning as one of its primary research focuses. Through the work of individual institutes at CIHR (notably the Institute for Health Services and Policy Research) and the work of the CIHR Science Lead on Health Human Resources, CIHR is attempting to provide more strategic direction to the overall research it funds in HHR and HHR planning. In late 2006, CIHR, in

collaboration with Health Canada and the Public Health Agency of Canada, hosted an initial symposium to begin a process of articulating a new HHR research agenda that would actively attempt to build bridges between the research and analysis needs of governments and stakeholders, and the interests and expertise of academic HHR researchers in Canada's universities. As has CHSRF, CIHR has focused significant attention and resources on improving its capacity and that of CIHR-funded researchers to engage in effective knowledge translation as part of an effort to insure that research results find their way into the policy processes of governments.

[29] Taken from the Canadian Health Services Research Foundation website. Retrieved on March 30, 2007, from www.chsrf.ca/research_themes/workplace_e.php.

[30] The Health Human Resources Planning Simulation Model for NPs in Primary Health Care™ is a needs-based planning tool that incorporates various elements of planning such as NP education/ training, retirement and migration and allows planners to test various policy scenarios before implementation. What is of particular value here is the process employed that brought together a wide range of actors – FPT governments and various stakeholders including employers and unions – as part of its work.

[31] Formed in 1991, the Health Action Lobby (HEAL) is a coalition of 30 national health associations and consumer advocacy organizations that is "dedicated to strengthening and protecting Canada's health care system." Originally formed out of concern that the federal government's role as the guarantor of the system had been eroded, HEAL's activities include lobbying governments on health care issues, coordinating and supporting multi-professional collaborations and plays a small role in funding health care related research. Although not exclusively an HHR-focused organization, HEAL's structure and membership make it one of the few truly multi-professional health care organizations on the national scene that bridges both professional and the public/private sector divides.

[32] The Canadian Association of Occupational Therapists Human Resources Working Group, which consists of representatives from CAOT, provincial regulatory organizations, provincial professional organizations, academic programs, education programs for support personnel and unions, was introduced in order to develop a strategy for human resource planning for occupational therapy. The strategy includes the following:

- A shared governance model in the form of a Leadership Group to oversee the strategy;
- A communication strategy that would be developed for all steps in the strategy; and
- Guiding Principles that would be considered in developing and implementing the strategy

[33] The Canadian Institute for Health Information provides a trend analysis of the Canadian health workforce. While, originally, the focus of this analysis was on physicians and nurses, supply-side data is now being collected on a slightly wider range of health providers. For example, the Health Human Resource Database Development Project, initiated in 2004, will eventually provide standardized national datasets for five regulated health professions: occupational therapists, pharmacists, physiotherapists, medical radiation technologists and medical laboratory technologists.

[34] The NPS, now under the auspices of the Canadian Coordinating Centre for Physician Resources (C3PR) of the Canadian Medical Association, provides information on physicians in clinical practice, in other medically related fields (e.g. teaching, administration, research) and physicians on sabbatical/temporary leave of absence. It is a collaborative project of the College of Family Physicians of Canada (CFPC), the Canadian Medical Association (CMA) and the Royal College of Physicians and Surgeons of Canada (RCPSC). It is funded by the CMA, CFPC, RCPSC, the Canadian Institute for Health Information and Health Canada.

[35] CAPER provides an annual census of physician-training experiences including the location of training, post-MD fields and how trainees are funded. The IMG database, currently in its initial stages, will track IMGS from the time they enter the Canadian medical assessment, training and licensure pathways until they begin practice in a Canadian province. CAPER is managed by an Executive Committee consisting of representatives from the following organizations: The Canadian Association of Interns and Residents; the Canadian Medical Association; Health Canada; provincial and territorial ministers of health; the College of Family Physicians of Canada; the Medical Council of Canada; the Association of Faculties of Medicine in Canada; and the Royal Collect of Physicians and Surgeons in Canada.

[36] The Student and Faculty Surveys provide information on annual admission, enrollment and graduate trends for Canadian nursing education in Canada. It shows the number of graduates eligible to enter the nursing workforce, and how many nurses are obtaining graduate and post-graduate education.

[37] CPHA's partners in *Moving Forward* include:

- National Association of Pharmacy Regulatory Authorities (NAPRA);
- Pharmacy Examining Board of Canada (PEBC);
- Canadian Association of Chain Drug Stores (CACDS);
- Canadian Society of Hospital Pharmacists (CSHP);
- Canadian Association of Pharmacy Technicians (CAPT);
- Association of Faculties of Pharmacy of Canada (AFPC); and
- Association of Deans of Pharmacy of Canada (ADPC).

[38] The Collaborating Centres for Public Health, for example, are housed within various research institutes across Canada. Likewise, the Canadian Council for Learning is a not-for-profit organization, which has a central office that focuses on research and knowledge mobilization, knowledge exchange and the developing and maintaining strategic partnerships, and several regional "knowledge centres" housed in existing research centres. Each centre focuses on a specific theme pertinent to Canadian education. These include the Aboriginal Learning Knowledge Centre based at the University of Saskatchewan; the Adult Learning Knowledge Centre led by the New Brunswick's College of Extended Learning; Early Childhood Learning Knowledge Centre, led by the Université de Montréal; the Health and Learning Knowledge Centre led by the University of Victoria; and the Work and Learning Knowledge Centre led by the Canadian Manufacturers & Exporters (CME) and the Canadian Labour Congress (CLC).

[39] The board members are elected by the members of the corporation, which is comprised of about 80 representatives from governments and stakeholder groups that have an interest in patient safety. The members of the corporation meet annually to vote on their common responsibilities and what directions the CPSI needs to move towards in addressing patient safety. One underlying success factor is the adoption of a common "Canadian" standpoint by the members – this means that all board members and the members of the corporation leave their provincial or professional interests at the door and work towards common Canadian solutions.

[40] These engagement structures are used by the Canadian Agency for Drugs and Technologies in Health.

[41] For example, in order to build capacity and use evidence-based information in Canada, the Canadian Agency for Drugs and Technologies in Health builds partnerships between with 50 organizations across Canada and 15 organizations from around the world. This means building on existing networks and the investments being made in research, assessment and appraisal across Canada and around the world. This information sharing is done through regular national consultations to identify health policy and research priorities, and an annual symposium that brings together Canadian leaders in the production and utilization of evidence-based information on drugs and other technologies in health.

[42] The following are member countries of the Alliance: Bangladesh; Cambodia; China; Fiji; India; Indonesia; Lao PDR; Myanmar; Nepal; Papua New Guinea; Philippines; Samoa; Sri Lanka; Thailand; and Vietnam.

[43] This structure was chosen in order to allow activities to be done at the country level and limit the amount of the budgets at the regional level.

[44] For more information, visit the Observatory of Human Resources website. Retrieved on April 24, 2007, from www.observatoriorh.org/eng/reform.html.

[45] Depending on the country, it can be part of a National Committee for HHR, a branch of a Health National Committee or a joint venture of the Planning Office of the Ministry of Health with some universities. In Brazil, Peru and Cuba, the Observatory is a division in the HHR secretariat in the Ministry of Health.

[46] A more complete list of the Asia-Pacific Alliance's activities is found on its website. Retrieved on May 31, 2007, from: www.aaahrh.org/aaah.php.

[47] For example, the PAHO Observatory supports the creation of national inter-institutional groups (ministries of health, universities, professional associations), which collect and analyze the stock, imbalances and trends in HHR, prioritize an agenda of issues to be tackled and advise on long- and medium-term policy development.

[48] Some countries, such as El Salvador, produce an annual update of the HRH database while others, such as Peru, hold a national conference with regional HHR managers to discuss research findings and regional perspectives.

[49] Bureau of Health Professions website. Retrieved on April 24, 2007, from: http://bhpr.hrsa.gov/healthworkforce/.

[50] The Regional HHRs Centers include the Center for Health Workforce Studies at the University of Albany; the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Center for Health Workforce Studies (CHWS); The Regional Center for Health Workforce Studies at the Center for Health Economics and Policy (CHEP); the Center for California Health Workforce Studies; the Midwest Center for Health Workforce Studies at the University of Illinois at Chicago; and the Southeast Regional Center for Health Workforce Studies at the University of North Carolina at Chapel Hill.

[51] The Student Nurse Intake Program (SNIP) provides the Scottish Executive with the number of qualified nurses and midwives entering the health workforce. More specifically, the SNIP represents a "bottom-up" approach to providing HHR planning models and data collection on supply and future demand trends. See for example, Mable, A., and J. Marriott. 2002. "Steady State: Finding a Sustainable Balance Point: International Review of Health Workforce Planning." Retrieved on April 1, 2007, from: www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-steadystate-etatstable/2002-steadystate-etatstable_e.pdf.

[52] This includes, among other things, a repository for information about the theories and principles of workforce planning, a searchable repository of reports, policies and articles that focus on research, evaluation, tools, case studies and statistics, and information on planning for change management and communications and understanding workforce motivation.

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